1

FOR STATE HEALTH DEPT.

10756

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10756

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medical Examiner's Office olang with farm PM3. Page 5 moy be retoined for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as o buriol-transit permit. File pages 1 and 2 with the State Department of Health or its designated ogent, prior to buriol, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 40 minutes
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   o. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Paw Paw, W. Va. (Mailing Address)
   d. STREET ADDRESS: 01-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: L. — Last: Avey

4. **DATE OF DEATH**: Month: Aug. — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 27, 1888

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Signal Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Berkley County, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Avey

14. MOTHER'S MAIDEN NAME: Mary Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Brown Funeral Home, Martinsburg, W. Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.

(b): CORONARY SCLEROSIS WITH THROMBOSIS — ----

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot I took chorge of the remoins described obove, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: August 8, 1966

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 11, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hedgesville Cemetery

23d. LOCATION (City or Town) (County) (State): Hedgesville, W. Va.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10757

CERTIFICATE OF DEATH

10751

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 441 GOETHE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LILLIAN — Middle: IOLA — Last: BARNARD
4. DATE OF DEATH: Month: AUGUST — Day: 8 — Year: 1966
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 9, 1888
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TELEPHONE OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: B & O R. R.
11. BIRTHPLACE (County & State, or foreign country): BERKELEY CO. W. VA.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: ISAAC B. CANNON
14. MOTHER'S MAIDEN NAME: MARY MARGARET ~~HUMAN~~ MURNAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 705-05-8135
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Hours / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1964 5:25 A.M. Aug, 19 66 that (I) (we) last saw the deceased alive on Aug 3 19 66 and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/8/66
22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 11, 1966
23c. NAME OF CEMETERY OR CREMATORY: Mt Hebron Cemetery
23d. LOCATION (City or Town) (County) (State): Winchester Frederick, VA.

24. FUNERAL DIRECTOR: John J. Hafer
ADDRESS: John J. Hafer, 230 Balto. Ave. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: AUG 11 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10758

CERTIFICATE OF DEATH

10752

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt. # 6
d. STREET ADDRESS: along U.S. Rt. 220 nr. Pinto
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First George Middle Michael Last Barton
4. DATE OF DEATH: Month August Day 6 Year 166
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: August 7, 1883
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md. U
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Barton
14. MOTHER'S MAIDEN NAME: Anna Duvall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 234-64-2869
17. INFORMANT: Mr. Thomas G. Barton Address: Rt. # 6 Cumb., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: from
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b): Arteriosclerosis — 2 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1- , 1964, to 8-6- , 1966, that (I) (we) last saw the deceased alive on 8-5- 1966, and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: Lewis Brings M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 8-9-66
22c. PHYSICIAN'S NAME (Type): Lewis Brings M.D.
22d. ADDRESS: Greene Street, Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/9/66
23c. NAME OF CEMETERY OR CREMATORY: St. Ambrose Cemetery
23d. LOCATION (City or Town) (County) (State): Cresaptown, Allegany, Md.
24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: AUG 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10759 10753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 81 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 111½ Blaul Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 111½ Blaul Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: ; Last: Beck

4. DATE OF DEATH: Month: Aug.(16)16; Day: ; Year: 19 66

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 25, 1885
9. AGE (In years lost birthday): 81 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Philip Beck
14. MOTHER'S MAIDEN NAME: Mary C. Lindamood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 212-18-1371A
17. INFORMANT: Address: Mr. Ronald Beck, Baltimore, Md.-Nephew

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Arteriosclerosis — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4-201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 7, 1966, to Aug 16, 1966 that (I) (we) last saw the deceased alive on Aug 7 19 66 and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: Clay E Durrett M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 19, 1966
22c. PHYSICIAN'S NAME (Type): Dr. Clay E. Durrett, M. D.
22d. ADDRESS: 236 Virginia Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 19, 1966
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: AUG 22 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10760 — 10754

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAVALE
d. STREET ADDRESS: 9 ASHBURY AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEROY — Middle RUSSELL — Last BECK
4. DATE OF DEATH: Month AUGUST — Day 7 — Year 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 2-5-1893
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brewery Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: FRANK BECK
14. MOTHER'S MAIDEN NAME: MARY PARDEW
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 220-10-2459
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Infarctions
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ~~Chronic Bronchitis--Pneumonia~~
(c): Arteriosclerotic Cardio-vascular disease
INTERVAL BETWEEN ONSET AND DEATH: days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 4: 25 A.M. Aug. , 1966, that (I) (saw) last saw the deceased alive on Aug. 6 1966, and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-7-66
22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/9/66
23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens
23d. LOCATION (City or Town) (County) (State): LaVale Allegany Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502
25a. REC'D BY REGISTRAR — DATE: AUG 9 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10761 — 10755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 5 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 6 WATER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARTHA — Middle: E. — Last: BENDER

4. DATE OF DEATH: Month: AUGUST — Day: 15, — Year: 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 20, 1887

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CYRUS ROBINSON

14. MOTHER'S MAIDEN NAME: SARAH GLASCOCK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 220-10-4165D

17. INFORMANT — Address: MRS. MADALYN THOMAS, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic brain syndrome
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): cerebral arteriosclerosis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 1year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Parkinson's disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-8-, 1966, to 8-15-, 1966, that (I) (we) last saw the deceased alive on 8-14- 19 66, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: G. Paige Strong — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. P. STRONG, M. D.

22d. ADDRESS: E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-17-66

23c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY

23d. LOCATION (City or Town) (County) (State): ECKHART, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10762 10756

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 1 HR. 35 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): CUMBERLAND
d. STREET ADDRESS: RT.#1, VALLEY ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREEMAN Middle A Lost BERGDOLL
4. DATE OF DEATH: Month AUG. Doy 7 Year 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 28, 1909
9. AGE (In yeors last birthday) 57 yrs. IF UNDER 1 YEAR Months Doys IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired employee B&ORR
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & Stote, or foreign country): W.VA., Petersburg
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GEORGE BERGDOLL
14. MOTHER'S MAIDEN NAME: HATTIE SHOEMAKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO. 232-22-3275
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b) Other Valvular Disease — 10 yrs
DUE TO (c) Criteria Unknown
4211
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 4/5/66, 19__, to 4/7/66, 19__, that (I) (we) last saw the deceased alive on 2 P.M., and that death occurred at 10 PM, from causes and on the date stated above.

22a. SIGNATURE: R. J. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8/9/66
22c. PHYSICIAN'S NAME (Type) R. J. Williams M.D.
22d. ADDRESS 122 S. Centre St Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8-10-66
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS: Ruth E. Silcox 404 Decatur St., Cumb., Md.
25a. REC'D BY REGISTRAR DATE AUG 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7,11,14,13 Film G379 8/17/66 mh

10763

CERTIFICATE OF DEATH

10757

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE
d. STREET ADDRESS: 715 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle — Last BOORDA
4. DATE OF DEATH: Month AUG — Day 1 — Year 1966

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-22-88
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Self.
11. BIRTHPLACE (County & State, or foreign country): Ukraine U.S.S.R.
12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: HERSHELL BOORDA
14. MOTHER'S MAIDEN NAME: SIBLEY Sybil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Nathon Boorda — Address: Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/12/66, 19__ to 8/1/66, 19__, that (I) (we) last saw the deceased alive on 8/1/66 19__, and that death occurred at 3:03 P.M. from causes and on the date stated above.

22a. SIGNATURE: J. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/1/66
22c. PHYSICIAN'S NAME (Type): DR. R.J WILLIAMS
22d. ADDRESS: 122 S CENTRE ST CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/5/66
23c. NAME OF CEMETERY OR CREMATORY: Hebrew Orthodox Cem
23d. LOCATION (City or Town) (County) (State): Mishawaka Ind.
24. FUNERAL DIRECTOR: Louis Stein Inc.
ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE AUG 4 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10758

1. PLACE OF DEATH
a. COUNTY Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE West Virginia
b. COUNTY Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Ridgeley
85-3
d. STREET ADDRESS Rural Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print) First Raymond Middle C. Last Burkhart
4. DATE OF DEATH Month August Day 6 Year 19 66
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 11, 1908
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Builder
10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield
11. BIRTHPLACE (State or foreign country) Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Orrie C. Burkhart
14. MOTHER'S MAIDEN NAME Elta Jack
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-9820
17. INFORMANT Richard Burkhart Address Rd.#1, Ridgeley, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, Left, Recent — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b) Coronary Sclerosis with Thrombosis — "
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Cumberland, Md.
22. DATE SIGNED August 6, 1966

2

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Aug. 9, 1966
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.
25a. REC'D BY REGISTRAR DATE AUG 9 1966
25b. REGISTRAR'S SIGNATURE J. Charles Jusge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if an event within 72 hours after death.

VR A15ME (5)
6M 1/66

1 2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10763 10759 10754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/28/1936
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Agnes — Middle — Last Campbell

4. DATE OF DEATH: Month August — Day 21, — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/5/1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert T. Longridge

14. MOTHER'S MAIDEN NAME: Mary E. Finch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Chronic degeneration
DUE TO (2) Arteriosclerosis & Hypertension
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b) DUE TO (3) Marked arterial deterioration
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/23/1953, 19__, to 8/21/66, 19__, that (I) (we) last saw the deceased alive on 8/20/66, 19__, and that death occurred at A. M, from the causes and on the date stated above. at 5:15 A.M.

22a. SIGNATURE: W. Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 8/22/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/23/66

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill

23d. LOCATION (City, town or county) (State): Moscow Mills Md.

24. FUNERAL DIRECTOR: E. J. Boal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

Item 18 Film 380 8-30-66 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

FOR STATE HEALTH DEPT.

10766 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 10760

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: D O A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 146 Independence St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

01-1

3. NAME OF DECEASED (Type or print): First: James — Middle: Allen — Last: Carder
4. DATE OF DEATH: Month: August — Day: 16 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 31, 1966
9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR Months: 2 Days: 16 — IF UNDER 24 HRS. Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Charles Floyd Carder
14. MOTHER'S MAIDEN NAME: Betty Warden Carder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Charles Floyd Carder, Route 1, Oldtown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation of Stomach Contents — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): (Asphyxiation) Aspiration of stomach contents
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 921.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: August 16, 1966
Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 17, 1966
23c. NAME OF CEMETERY OR CREMATORY: New Germany Methodist Cem
23d. LOCATION (City or Town) (County) (State): New Germany Garrett Md.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer 230 Balto Ave., Cumberland, Md
25a. REC'D BY REGISTRAR DATE: AUG 19 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained far your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

6-208808

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10767 Item 11 Film G381 10/3/66 mh 10761

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   c. LENGTH OF STAY IN 1b: 2 HRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: W. VA. — b. COUNTY: GRANT ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW CREEK
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): KCHRISTA Middle LYNN Last BABY GIRL CARR

4. DATE OF DEATH: Month Doy Year: AUGUST 21, 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-21-66

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 7 / Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: KENNETH P. CARR

14. MOTHER'S MAIDEN NAME: WANDA L. SITES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	20 min
DUE TO (b)	Generalized foetal anoxia	7 hrs 30 m
DUE TO (c)	Bilateral pneumothoraces	7 hrs 30 m

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Bilateral polycystic kidneys

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/21/66, 19 4:31 PM to 8/21, 19 66 that (I) (we) last saw the deceased alive on 8/21 19 66 and that death occurred at 4:31 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert J. Dawson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/22/66

22c. PHYSICIAN'S NAME (Type): DR. DAWSON

22d. ADDRESS: 500 Lee St Camp

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIED

23b. DATE THEREOF: 8/23/66.

23c. NAME OF CEMETERY OR CREMATORY: SOUTH BRANCH VALLEY MEMORIAL GARDEN

23d. LOCATION (City or Town) (County) (State): Petersburg W. Va.

24. FUNERAL DIRECTOR: Byron Kight — ADDRESS: Cumberland Md.

25a. REC'D BY REGISTRAR DATE: AUG 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10768 10762

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 6/3/1965
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
   d. STREET ADDRESS: 930 Centre Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Susan — Middle: Hester — Last: Clayton

4. **DATE OF DEATH**: Month: August — Day: 15, — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/8/1866

9. AGE (In years last birthday): 100 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Upper Tract, West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Kenneth Hill

14. MOTHER'S MAIDEN NAME: Elizabeth Ayers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599, Cumberland, Md. Address: Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Hypostatic pneumonia, chr. degenerative Vascular
DUE TO (b) (2) Arteriosclerosis general & cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
DUE TO (c) (3) Bilateral Cataracts

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/3/1965, 19__, to 8/15/66, 19__, that (I) (we) last saw the deceased alive on 8/13/66 19__, and that death occurred at 2:35 A.M. M, from causes and on the date stated above.

22a. SIGNATURE: Lee B. Mathews M.D.

ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 8/15/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/17/66

23c. NAME OF CEMETERY OR CREMATORY: Bayard Cemetery

23d. LOCATION (City or Town) (County) (State): Bayard, Grant Co. W. Va.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10769

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10763

1. PLACE OF DEATH
a. COUNTY Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b 15 Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. STREET ADDRESS 224 Baltimore St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Patrick Middle: Eugene Ashby Last: Cline
4. DATE OF DEATH Month: August Day: 5 Year: 1966

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 20, 1911
9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Fairchild-Hiller Aircraft Co.
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Wm. Cline
14. MOTHER'S MAIDEN NAME: Nellie Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 217-10-7246
17. INFORMANT: Mary Rose Graziani Address: 8 Pa. Ave. Cumb., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4201

DUE TO (b): CORONARY SCLEROSIS — **

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 5, 1966
Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: August 7, 1966
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cem.
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 9 1966
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10770

CERTIFICATE OF DEATH

10764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 25 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER
d. STREET ADDRESS: ROUTE #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CLEO — Middle MILTON — Last COX

4. DATE OF DEATH: Month AUGUST — Day 1 — Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 30, 1899

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orchardist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN COX

14. MOTHER'S MAIDEN NAME: ELIZABETH HARMON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 236-50-1313

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO (b): Pulmonary Emphysema & fibrosis with advanced Pulmonary Insuff. 10 yrs
DUE TO (c): A.S. Heart Disease and Cor Pulmonale secondary to above. 2 yrs.?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 July, 1966, to 1 Aug., 1966, that (I) (we) last saw the deceased alive on 31 July 19 66, and that death occurred at 8:05 A. M, from causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2 Aug. 66

22c. PHYSICIAN'S NAME (Type): WILLIAM A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 4, 1966

23c. NAME OF CEMETERY OR CREMATORY: Potomac Valley Memo. Pk.

23d. LOCATION (City or Town) (County) (State): Keyser, W. Va.

24. FUNERAL DIRECTOR: Rotruck-Chambers Fun. Home Inc. — ADDRESS: Keyser, W. Va.

25a. REC'D BY REGISTRAR DATE: AUG 4 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

BETTER BUSINESS FORMS, INC., BALTIMORE, MD. 21201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10771 — 10765

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4/22/1965
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland (Caroline)
d. STREET ADDRESS: 401 Caroline Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Agnes — Middle L. — Last Decker (Agnes Decker)
4. DATE OF DEATH: Month August — Day 18, — Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/27/1885
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Celanese Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania (Artemas)
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Wigfield
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): (1) Myocarditis Chr. degeneration
DUE TO: (2) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: (3) Chr. Brain Syndrome c Seizures
(c): (4) Paralysis Agitans + Pneumonia
260 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/22/66, 19__, to 8/18/66, 19__, that (I) (we) last saw the deceased alive on 8/18/66 19__, and that death occurred at A. M, from the causes and on the date stated above.

22a. SIGNATURE: W. Mathews M.D.
M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 8/18/1966
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug.22,1966
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery
23d. LOCATION (City, town or county) (State): Cumberland Md. Allegany
24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: AUG 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10772 — 10766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORRIGANVILLE P. O. Box 79
d. STREET ADDRESS: Fords Crossing 01-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY — Middle GERALDINE — Last DE VORE
4. DATE OF DEATH: Month AUGUST — Day 4 — Year 19 66
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 4-2-1916
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): HANCOCK, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES T. WALTERS
14. MOTHER'S MAIDEN NAME: CLARA STARLIPER Corrigansville, Md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No.
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Harvey J. DeVore — Address: P.O. Box 79 MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic carditis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs
DUE TO (b): Cardiac Decompensation — 3 yrs
DUE TO (c): Chronic Passive Congestion — 10 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 19 66 to 10:00 A.M., 19___, that (I) (we) last saw the deceased alive on ___ 19___, and that death occurred at ___ M, from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/5/66
22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT
22d. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/8/66
23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 9 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner - Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10772 — 10767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 27years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital D.O.A.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 413 Mechanic ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Edward — Middle: J. — Last: Dolphin

4. **DATE OF DEATH**: Month: August — Day: 26 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 20, 1920

9. AGE (In years last birthday): 45 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner

10b. KIND OF BUSINESS OR INDUSTRY: Dolphin Bar

11. BIRTHPLACE (State or foreign country): Shenandoha Penn.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John P. Dolphin (Deceased)

14. MOTHER'S MAIDEN NAME: Mary E. McGinness

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Delores Dolphin — Address: 413 Mechanic St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: Minutes
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Coronary Sclerosis — -----
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: August 26, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/29/66

23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter&Paul

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: AUG 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774 10768

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresaptown
d. STREET ADDRESS: Lone Oak Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonard, Middle: Calvin, Last: Emerick

4. DATE OF DEATH: Month: Aug. Day: 30 Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/1/32
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Pitts. Plate Glass
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Marshall C. Emerick
14. MOTHER'S MAIDEN NAME: Grace L. Garlick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service): Korean
16. SOCIAL SECURITY NO.: 215-26-9635
17. INFORMANT: Mrs. Betty Lou Emerick Address: Lone Oak Rd. Cresaptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, Right — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Sclerosis, generalized marked — ----
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: August 30, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/2/66
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 3 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

x

x x x x

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10773

CERTIFICATE OF DEATH

10769

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG, 21.1
d. STREET ADDRESS: RT.#2, BOX 130 Parkersburg Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
GLADYS	MAY	FILSINGER	AUGUST	8	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED [X]	8-18-1898	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife,	Own home	ECKHART, MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM PAPE	MARY E. HOLSINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No,	None	MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Min
DUE TO (b): Diabetic Arteriosclerosis Hypertensive Cardiac
DUE TO (c): Vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetic Gangrene of Toes Ex Thumb — 19. WAS AUTOPSY PERFORMED? YES ☐ NO [X]

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 66 19 10:30 to A.M. Aug 19 66, that (I) (we) last saw the deceased alive on Aug 7 19 66 and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [X] MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8/11/66

22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT — 22d. ADDRESS 133 VIRGINIA AVE. CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8/11/66	Eckhart Cemetery	Eckhart, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	AUG 15 1966	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10776 · 10776!

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 73 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 29 New Hampshire Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 29 New Hampshire Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna; Middle: Kesecker; Last: Fisher

4. DATE OF DEATH: Month: Aug.; Day: 16; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1892

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles L. Adams

14. MOTHER'S MAIDEN NAME: Margaret Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): no

16. SOCIAL SECURITY NO.: 220-10-9364

17. INFORMANT: Mrs. Margaret Bittner, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma ascending Ramus + floor L Mouth — INTERVAL BETWEEN ONSET AND DEATH: 19 mo
DUE TO (b): Metastasis to L + R Cervical Nodes — 14 mo
DUE TO (c): Leucoplacia posterior floor of Mouth — 20 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 143 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/4, 1965 to 8/16, 1966, that (I) (we) last saw the deceased alive on 8/15/1966, and that death occurred at 4:00 PM, from causes and on the date stated above.

22a. SIGNATURE: R. Rhett Rathbone — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/17/66

22c. PHYSICIAN'S NAME (Type): Dr.R. Rhett Rathbone, M.D.

22d. ADDRESS: 122 S. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.18,1966

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14771

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford
d. STREET ADDRESS: ---------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

85-3

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Eleanor — Last: Fisher

4. DATE OF DEATH: Month: August — Day: 25 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 4, 1891

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Dean

14. MOTHER'S MAIDEN NAME: Rose Bartlon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 234-46-6855A

17. INFORMANT Address: Mrs. Virginia Blankenship, Wiley Ford, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, Generalized — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours

5721

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ruptured Diverticulum of Ascending Colon 48 Hours
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: August 25, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 29, 1966

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City, town or county) (State): Frostburg, Maryland

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, 230 Balto Ave., Cumberland Md

25a. REC'D BY REGISTRAR DATE: AUG 30 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

X

X X X

X

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10778 10772

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT
d. STREET ADDRESS 105 OAK VIEW DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
GEORGE	E	FISHER	AUGUST	18	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	MARRIED X	2-14-89	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Railroad	ALLEGANY, MARYLAND	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE FISHER	NEHRING, WHILEMINA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	220-10-2689	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: Since March '66
DUE TO (b) a metastasis to the liver.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-2- 1966 to 8-18- 19 66 that (I) (we) last saw the deceased alive on 8-17- 19 66 and that death occurred at 6:00 A.M., from causes and on the date stated above.

22a. SIGNATURE Wm. F. Williams M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-18-66
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS
22d. ADDRESS CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
[illegible]	8/22/66	St. Peters	Westernport Md.

24. FUNERAL DIRECTOR E. L. Boal ADDRESS Westernport, Md.
25a. REC'D BY REGISTRAR DATE AUG 22 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. Death in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10778

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: D. O. A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ECKHART
   d. STREET ADDRESS: 41
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ANTONIO — Middle C. — Last GAUDIO

4. **DATE OF DEATH**: Month AUGUST — Day 3, — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 2, 1897

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIPPING DEPT.

10b. KIND OF BUSINESS OR INDUSTRY: CELANESE

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANCESCO GAUDIO

14. MOTHER'S MAIDEN NAME: MARIETTA SICOLI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-3570

17. **INFORMANT** Address: MRS. MATILDA GAUDIO, ECKHART, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
   (b): Coronary Sclerosis — —
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardio-Vascular disease

   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

   20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

   20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

   20d. INJURY OCCURRED While at work ☐ Not While at work ☐

   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

   20f. (City or town) (County) (State)

   21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

   ACTUAL SIGNATURE: Benedict Skitarelic M.D.
   EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.
   CHIEF MEDICAL EXAMINER ☐
   ASSISTANT MEDICAL EXAMINER ☐
   DEPUTY MEDICAL EXAMINER ☐
   DATE SIGNED: August 3, 1966
   Address (Street, city, town, or county): RD9, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 6, 1966

23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY

23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR — DATE: AUG 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10774

CERTIFICATE OF DEATH

10780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 HRS. 5 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1209 VIRGINIA AVE.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle E. Last GORDON

4. DATE OF DEATH: Month AUG. Day 11 Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: AUG. 16, 1895

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Boilermaker

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN GORDON

14. MOTHER'S MAIDEN NAME: ADA ADELE BELTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 214-05-9311

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b) Diabetes Mellitus — 5 yrs
DUE TO (c) Hypertension — 5 yrs
260X
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 10, 1966 at 10:10 A.M. to Aug 11, 1966, that (I) (we) last saw the deceased alive on Aug 11 1966 and that death occurred at ____ M, from couses and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 12, 1966

22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22d. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.14,1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland,Md.Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland,Md.

25a. REC'D BY REGISTRAR DATE: AUG 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10781 — 10775

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 113 Spruce Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 113 Spruce Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Lewis — Last: Gormer

4. DATE OF DEATH: Month: August — Day: 29 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9, 1881

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Allegany Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Isaac Gormer

14. MOTHER'S MAIDEN NAME: Anna C. Lloyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Charles Simmons, 116 Spruce St. Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Passive Congestion

DUE TO (b): Myocardial Degeneration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/17, 19 66, to 8/24, 19 66, that (I) (we) last saw the deceased alive on 8/26 19 66, and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Leo H. Ley Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/30/66

22c. PHYSICIAN'S NAME (Type): Leo H. Ley Jr.

22d. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 31, 1966

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Near Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: John J. Hafer, 230 Balto Ave. Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 31 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
20M S-63

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10776

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
   c. LENGTH OF STAY IN 1b: 3 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, 01 1
   d. STREET ADDRESS: 457 Goethe St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Louis — Middle: Edwin — Last: Grant

4. **DATE OF DEATH**: Month: August — Day: 9, — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 3, 1897

9. AGE (In years lost birthday): 69 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. truck driver

10b. KIND OF BUSINESS OR INDUSTRY: W. Md. Rwy.

11. BIRTHPLACE (State or foreign country): Franklin, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Grant

14. MOTHER'S MAIDEN NAME: Margaret Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,

16. SOCIAL SECURITY NO.: 705-12-2041

17. **INFORMANT** Address: Mrs. Elizabeth M. Grant 457 Goethe St. Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Coronary Sclerosis — -----
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.

22. DATE SIGNED: 9 August 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/12/66

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10782 — 10777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: CONNECTICUT
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SHELTON
d. STREET ADDRESS: 22 MEADOWBROOK DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORRIS — Middle William — Last GREEN

4. DATE OF DEATH: Month AUGUST — Day 7 — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-30-1921

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Sikorsky Aircraft

11. BIRTHPLACE (County & State, or foreign country): CONNECTICUT

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN GREEN

14. MOTHER'S MAIDEN NAME: SUZEL BEALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW11

16. SOCIAL SECURITY NO.: 042-18-9140

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Cardiac Arrest — minutes
DUE TO
(c): Acute Antero-septal Myocardial Infarction 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 5, 1966 to Aug. 7, 1966 that (I) ~~saw~~ last saw the deceased alive on Aug. 7 1966 and that death occurred at 1:58 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 7, 1966

22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 10

23c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery

23d. LOCATION (City or Town) (County) (State): Bridgeport, Connecticut

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox 404 Decatur St. Cumberland MD.

25a. REC'D BY REGISTRAR — DATE: AUG 10 1966

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to buriol, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

6-211585

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10784

CERTIFICATE OF DEATH

10778

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Cumberland
   c. LENGTH OF STAY IN 1b: 57 HRS. 21 MIN.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: W. Va.
   b. COUNTY:
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): rural
   d. STREET ADDRESS: Rt. 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Ellsworth — Last: Haggerty

4. **DATE OF DEATH**: Month: Aug. — Day: 22 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-20-66

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS.: Hours: 9 — Min.: 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & Stote, or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William E Haggerty

14. MOTHER'S MAIDEN NAME: Janet E Metz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	8
DUE TO (b)	Generalized anoxia	2 days
DUE TO (c)	Hyaline membrane disease	2 day

Conditians, if any, which gave rise ta immediate cause (a), stating the underlying couse last. 7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prematurity by date —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/20, 19 66 ta 8/22, 19 66 that (I) (we) last saw the deceased alive at 8/22 19 66, and that death occurred at 6:30 P.M. from causes and an the date stated abave.

22a. SIGNATURE: Robert J. Dawson M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8/22/66

22c. PHYSICIAN'S NAME (Type): ROBERT J. DAWSON — Dr. [illegible]

22d. ADDRESS: 500 GREENE ST Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/24/66

23c. NAME OF CEMETERY OR CREMATORY: Potomac Valley Gardens

23d. LOCATION (City or Town) (County) (State): Keyser W.V.

24. FUNERAL DIRECTOR: E. L. Boal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: AUG 25 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10785

CERTIFICATE OF DEATH

10779

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG,
c. LENGTH OF STAY IN 1b: 45 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 55 CENTENNIAL STREET

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): FROSTBURG,
d. STREET ADDRESS: 55 CENTENNIAL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: M. — Middle: ESTA — Lost: HARVEY
4. DATE OF DEATH: Month: AUGUST — Doy: 9th, — Year: 19 66

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 18th, 1897
9. AGE (If over 1 year last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FLORIST
10b. KIND OF BUSINESS OR INDUSTRY: FLORIST
11. BIRTHPLACE (County & Stote, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES A. MULLAN
14. MOTHER'S MAIDEN NAME: JEANETTE LLEWELLYN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 218-30-2484
17. INFORMANT: E. DANE HARVEY, ALLEGANY STREET, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis — 1 yr
DUE TO (c): Hypertension — several years
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from July 3, 1966, to Aug 9, 1966 that (I) (we) last saw the deceased alive on July 3 1966, and that death occurred at 7:30 A M, from causes ond an the date stoted obave.

22a. SIGNATURE: W O McLane — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 10 1966
22c. PHYSICIAN'S NAME (Type): W O McLane md
22d. ADDRESS: Frostburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-11-66
23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK,
23d. LOCATION (City or Town) (County) (Stote): FROSTBURG, MD.

24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR. — ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: AUG 12 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

1 3

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10786

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10786

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 18 FROST AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDITH; Middle M.; Last HILL

4. DATE OF DEATH: Month AUGUST; Day 17; Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 3, 1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF-EMPLOYED

10b. KIND OF BUSINESS OR INDUSTRY: SEAMSTRESS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SAMUEL MURPHY

14. MOTHER'S MAIDEN NAME: MINNIE BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-6186A

17. INFORMANT: CHARLES HILL, PEARL RIVER, N. Y. 10965 Address 34 COLONIAL CT.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Coronary Sclerosis
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22. DATE SIGNED: August 17, 1966

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

Address (Street, city, town, or county): RD 9, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 20, 1966

23c. NAME OF CEMETERY OR CREMATORY: FB'G. MEMORIAL PARK

23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MARYLAND.

25a. REC'D BY REGISTRAR DATE: AUG 22 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10787 10781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 7yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 171 Center
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kathryn; Middle: May; Last: Huff

4. DATE OF DEATH: Month: Aug.; Day: 23; Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Mar. 9 1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Midlothian
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Fisher
14. MOTHER'S MAIDEN NAME: Mary Ellen Plummer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-16-5982
17. INFORMANT: Address: Clay Huff, R. D. I-Box I37, LaVale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute brain syndrome
DUE TO (b): Cerebrovascular accident
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X
INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Primary carcinoma of liver with metastases
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 15, 1966, to Aug 23, 1966, that (I) (we) last saw the deceased alive on Aug. 22 1966, and that death occurred at 7:45 AM, from causes and on the date stated above.

22a. SIGNATURE: A. Paige Strong M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 25, 1966
22c. PHYSICIAN'S NAME (Type): A. Paige Strong, M. D.
22d. ADDRESS: 167 E. Main St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-26-1966
23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Frostburg Allegany Md.

24. FUNERAL DIRECTOR: Hafer Funeral Home (Pearl H. Mattingly)
ADDRESS: Frostburg, Md,
25a. REC'D BY REGISTRAR DATE: AUG 29 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10788 10782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 411 Decatur St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: L. Last: Hughes
4. DATE OF DEATH: Month: 8 Day: 28 Year: 19 66

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 19, 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Allegany, County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Moran
14. MOTHER'S MAIDEN NAME: Briget Gillmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-10-2956B
17. INFORMANT: Patient's Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Cerebral Thrombosis — 4 wks
DUE TO (c): Arteriosclerosis — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 27, 1966, to Aug. 28, 1966, that (I) (we) last saw the deceased alive on Aug 27 19 66, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Clay E Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/29/66
22c. PHYSICIAN'S NAME (Type): Clay E. Durrett M.D.
22d. ADDRESS: 236 Virginia Ave Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/31/66
23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Alleg Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE: SEP 1 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10788

CERTIFICATE OF DEATH

10789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 10 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: 406 SOUTH ST. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
JOHN	W.	HUNT	AUGUST	17	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE		JAN. 17, 1876	90 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Engineer	Railroad	VIRGINIA Waynesboro	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SAMUEL HUNT	Frances Ellison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	705-07-6604	MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	Imo
DUE TO (b)	Chronic myocardetes	2 yrs
DUE TO (c)	Arteriosclerosis	15 yrs

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 15, 1966, 10 P.M. to Aug 17, 1966, that (I) (we) last saw the deceased alive on July 17 1966, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE				22b. DATE SIGNED
Clay E. Durrett M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	Aug 18, 1966

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. CLAY E. DURRETT	236 VIRGINIA AVE. CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8-20 - 1966	Davis Memorial Cemetery	Cumberland, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli Cumberland, Md.	AUG 23 1966	J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10784

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RT. 1, FROSTBURG, MD. Box 529
   c. LENGTH OF STAY IN 1b: 15 Yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. 1, FROSTBURG, MD. Box 529
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: WILBUR — Middle: J. — Last: JENKINS

4. **DATE OF DEATH**: Month: AUG. — Day: 22nd, — Year: 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 12TH, 1912

9. AGE (In years last birthday): 54 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ARTHUR JENKINS

14. MOTHER'S MAIDEN NAME: LYDIA MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-10-4152

17. INFORMANT: MRS. MARY G. JENKINS, RT.1, FROSTBURG, MD. — Address: BOX 529

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis, Left — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): Coronary Sclerosis — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 22, 1966

EXAMINER'S NAME (Type): Benedict SKITARELIC, MD — Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-25-66
22c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK
22d. LOCATION (City, town, or county): FROSTBURG, (State): MD.

23. FUNERAL DIRECTOR: JOSEPH R. DURST, SR. — ADDRESS: FROSTBURG, MD.

24a. REC'D BY REGISTRAR — DATE: AUG 26 1966

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10791 — 10785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c. LENGTH OF STAY IN 1b: 2/26/1966	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 01-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary 90	d. STREET ADDRESS: 144½ Bedford Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Anna Cornelia	Middle	Last: Key	4. DATE OF DEATH	Month: August	Day: 5,	Year: 19 66
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 3/2/1887	9. AGE (In years last birthday): 79 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired; Beautician	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): New Florence, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME: Jessie Shipley		14. MOTHER'S MAIDEN NAME: Anna Beckman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 100-16-2652	17. INFORMANT: P.O.Box 599, Allegany County Infirmary records.	Address: Cumberland, Md.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Chronic degeneration
DUE TO: (2) Residuals of Cerebral apoplexy (cva)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
(b) DUE TO: Speech defect
(c) (3) Arteriosclerosis general + cerebral

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2/26/66, 19___, to 8/5/66, 19___, that (I) (we) last saw the deceased alive on 8/4/66, 19___, and that death occurred at 3:30 A.M. at A. M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 8/5/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Aug. 8, 1966	Rose Hill Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, 230 Balto. Ave., Cumberland, Md.	AUG 8 1966	[signature]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if one is not within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10792

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10786

1. **PLACE OF DEATH**
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital--DOA

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale — Route #1
   d. STREET ADDRESS: Homewood Addition
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Henry — Middle: Michael — Last: Knieriem, Jr

4. **DATE OF DEATH**: Month: August — Day: 28 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 8, 1910

9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager- Hudson Oil Co-

10b. KIND OF BUSINESS OR INDUSTRY: Greene St, City

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Knieriem

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Diehl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
    (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 214-05-6192

17. **INFORMANT**: Mrs. Leola Knieriem — Address: Route #1 LaVale, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Coronary Thrombosis, Left — INTERVAL BETWEEN ONSET AND DEATH: Sudden
    DUE TO (b): Corona ry Sclerosis — 4201 — -----
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    DUE TO (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: August 28, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/31/66

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: Ruth E. Silcox — ADDRESS: Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: AUG 31 1966

25b. REGISTRAR'S SIGNATURE: Charles Jugg

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10793 **CERTIFICATE OF DEATH** 10787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12/13/1965
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rawlings
d. STREET ADDRESS: Rt.#5, Cumberland, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella Rebecca — Middle: — Last: Lambert

4. DATE OF DEATH: Month: August — Day: 4, — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9/15/1876

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired:School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (County & State, or foreign country): Berea, West Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Martin Wilson

14. MOTHER'S MAIDEN NAME: Mary Jane Nay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: P.O.Box 599, Address Cumberland, Md. — Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis Chr degenerative — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arterio Sclerosis, General
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Partial Blindness
Partial Deafness

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12/13/65, 19__, to 8/4/66, 19__, that (I) (we) last saw the deceased alive on 8/3/66, 19__, and that death occurred at A. M. at 8:10 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] — ATTENDING M.D. PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 8/4/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/6/66

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

23d. LOCATION (City or Town) (County) (State): Harrisville, RitchieCo. W. Va.

24. FUNERAL DIRECTOR — **ADDRESS**: H. Wayne George — Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 8 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10794 10788

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Rockville Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: E. — Last: Lintz

4. DATE OF DEATH: Month: August — Day: 3 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 13, 1886

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Herbert Stevens — Address: Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — "Son"

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
4201
DUE TO (b): Atrial Flutter — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Cardiovascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19.58 to Aug 3., 19 66 that (I) (we) last saw the deceased alive on Aug 2 19 66, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: L Miles MD M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8.4.66

22c. PHYSICIAN'S NAME (Type): L. R. MILES JR., M.D.

22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/5/66

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn

ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: AUG 8 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10795 10789

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 30 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 713 LOUISIANA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle — Last MC CALL

4. DATE OF DEATH: Month AUGUST — Day 21 — Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-13-1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): MARYLAND Shaft

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: GEORGE MC CALL

14. MOTHER'S MAIDEN NAME: ELIZABETH WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): W.W1 I.

16. SOCIAL SECURITY NO.: 214-05-8194

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis to liver, peritoneal cavity — INTERVAL BETWEEN ONSET AND DEATH: 6 wks
DUE TO (b): Primary Site Carcinoma of the DUODENUM — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1520

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April, 19 66, to August, 19 66, that (I) (we) last saw the deceased alive on Aug 21 19 66, and that death occurred at 1:15 PM, from causes and on the date stated above.

22a. SIGNATURE: S. G. Weisman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/22/66

22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN

22d. ADDRESS: 59 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-24-66

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 25 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10796 10796

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 28 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admissian)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): MOSCOW
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle L. — Lost MC CUTCHEON
4. DATE OF DEATH: Month AUGUST — Day 13 — Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-4-1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Samuel McCutcheon
14. MOTHER'S MAIDEN NAME: Fanny Jacobs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Acute Myocardial dyfunction — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b) (2) Arteriosclerotic Cardiovascular disease — 7
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/16, 1966 to 8/13, 1966 that (I) (we) last saw the deceased alive on 8/13/1966, and that death occurred at 11:05 PM, from causes and on the date stated above.

22a. SIGNATURE: Walter N. Himmler — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/15/66
22c. PHYSICIAN'S NAME (Type): DR. W. N. HIMMLER
22d. ADDRESS: 412 N. MECHANIC ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/16/66
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City or Town) (County) (State): Moscow, A. Md
24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: AUG 17 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit (See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. Such in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10797

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10791

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, 21-1
   d. STREET ADDRESS: 705 Gephart Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First: Helen; Middle: Mae; Last: McFarlane

4. DATE OF DEATH: Month: August; Day: 4; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 30, 1917

9. AGE (In years last birthday): 48 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hostess

10b. KIND OF BUSINESS OR INDUSTRY: Lodge Club Room

11. BIRTHPLACE (State or foreign country): Alliance, Ohio

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William E. Kershen

14. MOTHER'S MAIDEN NAME: Frances B. Shore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-8681

17. INFORMANT: Miss Melva S. McFarlane, Address: Cumb. Md. 705 Gephart Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Coronary Sclerosis with thrombosis, left — --
   DUE TO
   (c):

   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Do. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

2

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: August 4, 1966

2

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/6/66

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 8 1966

25b. REGISTRAR'S SIGNATURE: JCharles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10793 10792

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 01-1
d. STREET ADDRESS: 424 Louisiana Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Mary	Ellen	Moore		Aug.	29	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Sept. 9. 1883	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Housework	Martinsburg, W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Patrick Moore	Margaret O'Connor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—		Mrs. Robt. W. Reed	Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Month?

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Art. C.V.D. — many years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 8-30-60, 19___, to 8-29-66, 19___, that (I) (we) last saw the deceased alive on 8-9-66, 19___, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: T. F. Lusby — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-30-66

22c. PHYSICIAN'S NAME (Type): T. F. Lusby MD — 22d. ADDRESS: Box 366 La Valek Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	9/1/66	St Marys Cem.	Cumberland Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md.	AUG 31 1966	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10798 10798

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Jackson Street
e. IS RESIDENCE ON A FARM? YES ☐ ND ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: V. — Last: Morris

4. DATE OF DEATH: Month: August — Day: 15 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/23/1880

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): McKinn, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Creed Barker

14. MOTHER'S MAIDEN NAME: Eliza Markle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Basil Morris — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] "Son"

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	7 days
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	ACVD	years
DUE TO (c)	Arteriosclerosis	years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ ND ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to Aug 15, 1966, that (I) (we) last saw the deceased alive on Aug 14 1966, and that death occurred at 8 p M, from the causes and on the date stated above.

22a. SIGNATURE: L.R. Miles M.D. — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8·16·66

22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR. M.D.

22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/18/66

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town or county) (State): Lonaconing, Md.

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10800 — 10794

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 40 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 624 N. CENTRE STREET

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 624 N. CENTRE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: LEE — Last: MOYER

4. DATE OF DEATH: Month: AUGUST — Day: 15 — Year: 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: MARCH 28, 1907

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIANS HELPER

10b. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP.

11. BIRTHPLACE (County & State, or foreign country): PETERSBURG, W. VA.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CHARLES E. MOYER

14. MOTHER'S MAIDEN NAME: MARY KYLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 214 07 4215

17. INFORMANT: MRS. E. GRACE MOYER — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

DUE TO (b): Coronary Artery Disease — 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus — 21 yrs

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1/29, 19 65 to 8/15, 19 66, that (I) (~~we~~) last saw the deceased alive on 8/3 19 66, and that death occurred at 4:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: J. A. Pagan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/16/66

22c. PHYSICIAN'S NAME (Type): J. A. PAGAN, M.D.

22d. ADDRESS: 5 POTOMAC ST. RIDGELEY, W. VA.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 18, 1966

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: AUG 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10801 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 10795

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Wellersburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brian — Middle: Robert — Lost: Murray
4. DATE OF DEATH: Month: August — Doy: 4, — Year: 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1966
9. AGE (In yeors lost birthdoy) yrs.: IF UNDER 1 YEAR Months: 1 Days: 2 — IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Hays Harmon
14. MOTHER'S MAIDEN NAME: Judy Murray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Judy Murray, Wellersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGENITAL HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ----
DUE TO (b): (ASPIRATION OF STOMACH CONTENTS, TERMINAL) — MINUTES
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 7545

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** thot I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, ond in my opinion deoth resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: AUGUST 4, 1966
Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 6, 1966
23c. NAME OF CEMETERY OR CREMATORY: Wellersburg Cemetery
23d. LOCATION (City or Town) (County) (State): Wellersburg, Pa.
24. FUNERAL DIRECTOR: Howard H. Feigley — ADDRESS: Hyndman, Pa.
25a. REC'D BY REGISTRAR DATE: AUG 8 1966
25b. REGISTRAR'S SIGNATURE: Roberts Judge

VR A15ME (5) 6M 1/66

6-208956

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10802

CERTIFICATE OF DEATH

10796

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL	d. STREET ADDRESS: 407 MARYLAND AVE. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ROSE	C.	NEWHOUSE	AUGUST	22	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		7-30-84	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	BURLINGTON, W.VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN CANNON (D)	MARY (KROUSE) CANNON (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	PT'S CHART

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism

DUE TO (b): Femoral Artery - Vein Graft

DUE TO (c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardio Vascular Disease + Congestive failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 8-15, 1966, to 8-22, 1966, that ~~(I)~~ (we) last saw the deceased alive on 8-22 1966, and that death occurred at 3 P.M., from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
L Michael Glick M.D.		8-26-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR SPIGGLE & GLICK M.D.	126 N. SMALLWOOD ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	AUG., 25, 1966	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	AUG 29 1966	J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10803 **CERTIFICATE OF DEATH** 10797

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 39 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 01-1 d. STREET ADDRESS: ALGONQUIN HOTAL e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First MARY — Middle H. — Last OFFUTT	4. DATE OF DEATH: Month AUGUST — Day 31, — Year 19 66
5. SEX: FEMALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 1-11-1883 — 9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JACOB HUMBIRD	14. MOTHER'S MAIDEN NAME: FANNIE ELDER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Since 8/16/66
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
490 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive C.V.D. Diverticulitis Profound Senility — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-23- 1966 to 8-31- 1966 that (I) (we) last saw the deceased alive on 8-30- 1966 and that death occurred at 12. 10 AM from causes and on the date stated above.

22a. SIGNATURE: Wm. F. Williams M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-31-66.

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS — 22d. ADDRESS: 122 S. CENTRE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/3/66	Hillcrest Burial Pk	Cumberland Md.

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE SEP 2 1966 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10804

CERTIFICATE OF DEATH

12132

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: HOMES APT. C. FT. CUMBERLAND
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALPHA — Middle E — Last PAYNE

4. DATE OF DEATH: Month AUG. — Day 31 — Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: JAN. 8, 95

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (County & State, or foreign country): W.VA. POINTS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM MORELAND

14. MOTHER'S MAIDEN NAME: LIZZIE ANDERSON Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-05-5545

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Right Bundle Branch Block
DUE TO
(c): ~~Pulm~~ Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Partial Small Bowel Obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-27, 19 66, to 8-31, 19 66, that (I) (we) last saw the deceased alive on 8-31 19 66, and that death occurred at 10:15 A. M, from causes and on the date stated above.

22a. SIGNATURE: William P. James — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/2/66

22c. PHYSICIAN'S NAME (Type): DR. WILLIAM P. IAMES

22d. ADDRESS: 441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 2, 1966

23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10805 — 10798

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 55 Years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 107 Bellevue Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 107 Bellevue Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Ready

4. DATE OF DEATH: Month: August — Day: 29 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 14, 1880

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Maryland Allegany Co

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Ready

14. MOTHER'S MAIDEN NAME: Ann Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Lenora Ready — Address: 107 Bellevue St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Few Days
DUE TO (b): GI carcinoma — 10 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
159X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-24, 1966, to 8-38, 1966, that (I) (we) last saw the deceased alive an 8-29 1966, and that death accurred at 5:4 M, fram causes and an the date stated abave.

22a. SIGNATURE: Gina M. Glick M.D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-29-66

22c. PHYSICIAN'S NAME (Type): Gina M. Glick M.D.

22d. ADDRESS: 126 N. Smallwood St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/31/66

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City or Town) (County) (State): Mt Savage Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox — ADDRESS: Cumberland, Maryland 21502

25a. REC'D BY REGISTRAR DATE: AUG 31 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10806

CERTIFICATE OF DEATH

10799

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 yr., 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): Westernport
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hannah; Middle; Lost Riggleman

4. DATE OF DEATH: Manth 8; Day 21; Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: June 6, 1880

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Haurs; Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast of warking life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, ar fareign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fisher Turner

14. MOTHER'S MAIDEN NAME: Margaret Blizzard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elmer Riggleman Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Hypocardiac Obstruction Senile
DUE TO (b) (2) Arterio Sclerosis, General + Cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Senile —

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City ar town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 2, 1965, to Aug. 21, 1966, that (I) (we) last saw the deceased alive an Aug. 20 1966, and that death occurred at 1 P. M, from causes and an the date stated above.

22a. SIGNATURE: L. B. Mathews M.D.
M.D. ATTENDING PHYS. ☐ MED. OIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.

22d. ADDRESS 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 8/24/66

23c. NAME OF CEMETERY OR CREMATORY Bloomington

23d. LOCATION (City or Town) Bloomington (County) (State) Md.

24. FUNERAL OIRECTOR E. L. Broad ADDRESS Westernport, Md.

25a. REC'D BY REGISTRAR DATE AUG 24 1966

25b. REGISTRAR'S SIGNATURE Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10807

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10800

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 21-1
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

I

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: Naomi — Last: Rockwell

4. DATE OF DEATH: Month: August — Day: 10 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 7, 1909

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Winchester, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nelson E. Fadley

14. MOTHER'S MAIDEN NAME: Ruth N. Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Patricia Busch, Rt.2, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 8-10-1966

Address (Street, city, town, or county): Rt.9 Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 13, 1966

23c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery

23d. LOCATION (City or Town) (County) (State): Near Ridgeley, W. Va.

24. FUNERAL DIRECTOR: ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10808 — **CERTIFICATE OF DEATH** — 10801

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Frostburg~~ Cumberland
c. LENGTH OF STAY IN 1b: 59 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 110 Center Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Frank	B.	Rooney	August	15	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		8-15-87	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	ABL	Zilhman, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Rooney	Sarah Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	216-09-0620	Pt. Chart

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion, extension of older occlusion — Interval between onset and death: Minutes
DUE TO (b): Arteriosclerotic CVD with cardiomegaly and chronic, intractable congestive failure — Interval between onset and death: 8 weeks
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute CVA 7-29-66; Chronic lymphocytic Leukemia; Prostate enlargement

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 17, 1966, to Aug. 15th, 1966, that (I) (we) last saw the deceased alive on Aug. 15th 1966, and that death occurred at 5:10 P M, from causes and on the date stated above.

22a. SIGNATURE: Wyand D Doerner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-18-66
22c. PHYSICIAN'S NAME (Type): Dr. Wyand Doerner
22d. ADDRESS: 414 N. Mechanic St, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	AUG. 18, 1966	ST. MICHAEL'S CEMETERY	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, SR., FROSTBURG, MD.	AUG 22 1966	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10809

CERTIFICATE OF DEATH

10802

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 492 BOWLING AVE.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ora[illegible] — Middle: Marie — Last: ROY

4. DATE OF DEATH: Month: AUGUST — Day: 29 — Year: 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 29, 1921

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Cable Mfg.

11. BIRTHPLACE (County & State, or foreign country): DAVIS, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RAY EVANS

14. MOTHER'S MAIDEN NAME: Lura[illegible] ROTH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-14-4544

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b): Uremia — obstruction both ureters
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
171 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19 64, to Aug 29, 19 66, that (I) (we) last saw the deceased alive on Aug 29 1966, and that death occurred at 1:33 P.M. from causes and on the date stated above.

22a. SIGNATURE: W Royce Hodges — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/31/66

22c. PHYSICIAN'S NAME (Type): DR. W. ROYCE HODGES

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/1/66

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 3 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10810

CERTIFICATE OF DEATH

10809

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Meyersdale Pa 75-3
d. STREET ADDRESS: 415 Center St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanor — Middle: M — Lost: Rumgay

4. DATE OF DEATH: Month: AUG. — Doy: 5 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 6 1917
9. AGE (In yeors last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House - Lady
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Meyersdale Pa Somerset Co
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Andrew J. Romgay
14. MOTHER'S MAIDEN NAME: Maude Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Marguerite Romgay — Address: 415 Center St Meyersdale Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Hemmhage
DUE TO
(b): Hypertensive Cardiovascular disease
DUE TO
(c):
443 X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH: 3 hrs. at least 5 yrs -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 8/5, 1966, to 8/5, 1966, thot (I) (we) last saw the deceased alive an 8/5 1966, and that death occurred at 3 P. M, from causes and on the date stoted above.

22o. SIGNATURE: Martin M Rothstein M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/6/66
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D.
22d. ADDRESS: 48 BROADWAY - FROSTBURG - MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 8 66
23c. NAME OF CEMETERY OR CREMATORY: Sts Philip & James Cemetery
23d. LOCATION (City or Town) (County) (State): Meyersdale Somerset Pa

24. FUNERAL DIRECTOR: William Rowe Price
ADDRESS: Meyersdale Pa
25o. REC'D BY REGISTRAR DATE: AUG 11 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10811 **CERTIFICATE OF DEATH** 10804

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 23 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 111 SHAW PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle A Last SCOLLICK
4. DATE OF DEATH: Month AUG. Day 16 Year 19 66
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 28, 98
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ANTHONY MAPHIS
14. MOTHER'S MAIDEN NAME: FANNIE SHANK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Respiratory Failure & Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Pedal Cyanosis or Arteriosclerotic disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 583X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral pneumonitis - gastrointestinal hemorrhage
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-2, 1966, to 8-16, 1966, that (I) (we) last saw the deceased alive on 8-16 1966, and that death occurred at 2:15 PM, from causes and on the date stated above.

22a. SIGNATURE: William P James — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/18/66
22c. PHYSICIAN'S NAME (Type): DR. WILLIAM P. JAMES
22d. ADDRESS: 441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 19, 1966
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
23d. LOCATION (City or Town) (County) (State): Romney, West Virginia
24. FUNERAL DIRECTOR ADDRESS: Philip B. Wendt 121 Memorial Ave. Cumb. Md.
25a. REC'D BY REGISTRAR DATE: AUG 22 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10812

CERTIFICATE OF DEATH

10805

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 4 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
   d. STREET ADDRESS: 319 COLUMBIA ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY — Middle MARGARET — Last SHAW

4. **DATE OF DEATH**: Month AUGUST — Day 4 — Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-31-66

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 4 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: MARY LAUDER SHAW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Brain Damage — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO (b): subdural hematoma, intracerebral hemorrhage, thrombocytopenia
   DUE TO (c): Anemia Secondary
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): prematurity, Breech delivery

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/31, 1966, to 8/4, 1966, that (I) (we) last saw the deceased alive on 8/4, 1966, and that death occurred at 4:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Elizabeth Bruns — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. E. BRINGS

22d. ADDRESS: 55 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/9/66

23c. NAME OF CEMETERY OR CREMATORY: ALLEGANY COUNTY CEMETERY

23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR — DATE AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

6-209096

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10813

CERTIFICATE OF DEATH

10806

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 301 N. BEL AIR DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARIE — Middle A. — Last SHERMAN

4. DATE OF DEATH: Month AUGUST — Day 11 — Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 16, 1924

9. AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): NEW JERSEY

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH FURRER

14. MOTHER'S MAIDEN NAME: JOSEPHINE WOTJEK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic (bone & lung) Ca. — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(b): Primary Adenoca Rt breast — 4 yrs ago
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-24-66, 16:40 to P.M., 19__, that (I) (we) last saw the deceased alive on Aug 11 1966, and that death occurred at ___ M, from causes and on the date stated above.

22a. SIGNATURE: A. J. Mirkin M.D. — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/12/66

22c. PHYSICIAN'S NAME (Type): DR. A.J. MIRKIN

22d. ADDRESS: 115 S. CENTRE ST. CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 14, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, 230 Balto Ave., Cumberland, Md

25a. REC'D BY REGISTRAR — DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10814

CERTIFICATE OF DEATH

10807

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: W. VA.
b. COUNTY: MINERAL
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn): BURLINGTON
d. STREET ADDRESS: P.O. BOX 24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

85-3

50

3. NAME OF DECEASED (Type ar print): First NETTIE — Middle L. — Last SHOEMAKER

4. DATE OF DEATH: Month AUGUST — Day 14, — Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-18-1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN B. MARTIN

14. MOTHER'S MAIDEN NAME: MARTHA E. BOWMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Generalized metastases from	
DUE TO (b)	Removal of Hypernephroma (Rt.)	Since
DUE TO (c)	in Winchester Hosp. Sept '65	Sept '65

180X

Conditians, if any, which gave rise ta immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Manth, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at wark ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)

20f. (City or tawn) (Caunty) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 8-4-19 66 to 8-14-19 66 that (I) (~~we~~) last saw the deceased alive an 8-13-19 66 and that death accurred at 4:59 AM, fram causes and an the date stated abave.

22a. SIGNATURE: W. F. Williams M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-15-66

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 17 Aug 66

23c. NAME OF CEMETERY OR CREMATORY: Arnold Cemetery

23d. LOCATION (City or Town) (County) (State): Hampshire Co. W. Va.

24. FUNERAL DIRECTOR: Allen M. Rotruck — ADDRESS: Keyser, W. Va.

25a. REC'D BY REGISTRAR DATE: AUG 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10815

CERTIFICATE OF DEATH

10808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   c. LENGTH OF STAY IN 1b: 1HR 50 MI.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, 01-1
   d. STREET ADDRESS: 324 ARCH ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): MR. First KERMIT Middle M. Last SITES

4. DATE OF DEATH: Month AUG. Day 14. Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/17/11

9. AGE (In years last birthday): 55 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driver

10b. KIND OF BUSINESS OR INDUSTRY: Tractor-Trailer

11. BIRTHPLACE (County & State, or foreign country): W.VA. Petersburg

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES SITES

14. MOTHER'S MAIDEN NAME: MARY MALLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) Peace Time

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL, Address CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis
   DUE TO (b): Coronary Artery Disease
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
   INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Manth, Day, Yeor Haur o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/14/65, 19__, to 8/14/66, 19__, that (I) ~~(we)~~ last saw the deceased alive on 8/14/66 19__, and that death occurred at 1.50PM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/15/66

22c. PHYSICIAN'S NAME (Type): Dr. Richard J. Williams, M.D.

22d. ADDRESS: 122 S. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 17, 1966

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 18 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10816 **CERTIFICATE OF DEATH** 10809

1. PLACE OF DEATH
a. COUNTY: Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Cumberland
d. STREET ADDRESS: 34 Baltimore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Paul; Middle; Lost Soulanticas

4. DATE OF DEATH: Month Aug. Doy 12 Year 1966

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/12/89
9. AGE (In yeors lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Shine
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anastassion Soulanticis
14. MOTHER'S MAIDEN NAME: Assina (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT Address: Allegany Co. Slyvlin Retreat Cumb Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Otb degenerative
DUE TO: (2) Arteriosclerosis General + Cerebral
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse last.
(b) DUE TO: (3) 17:11 Senile Psychosis
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 7, 1963, to Aug. 12, 1966, that (I) (we) last saw the deceased alive an Aug. 11 1966, and that death accurred at 5 A. M, from causes and an the date stated abave.

22a. SIGNATURE: L. B. Mathews M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/66
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Pk
23d. LOCATION (City or Town) (County) (State): Cumberland Md.

24. FUNERAL DIRECTOR: Lowe Stein Inc.
ADDRESS: Cumb. Md
25a. REC'D BY REGISTRAR DATE AUG 15 1966
25b. REGISTRAR'S SIGNATURE: Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ony event, within 72 hours after death.

VR A15 (4)
20 M 1/66

B 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10817 — 10810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: W.Va. — b. COUNTY: Hampshire
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Romney, W.Va.
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

85-3

3. NAME OF DECEASED (Type or print): First: Susan — Middle: J. — Last: Stump

4. DATE OF DEATH: Month: August — Day: 17, — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 24, 1891

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Household Duties

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Stump

14. MOTHER'S MAIDEN NAME: Belle Millar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elsie Stump — Address: Romney W.Va. Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrene of Bowel — INTERVAL BETWEEN ONSET AND DEATH: 36 Hrs.
DUE TO (b): Mesenteric Thrombosis — 36 Hrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5702

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [XX] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at Home injuring left Knee

20c. TIME OF INJURY Month, Day, Year: Hour 3:00 p.m. Aug. 12 1966

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Rt. 4 Romney, Hamp. W.Va.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22. DATE SIGNED: August 17, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-20-66

23c. NAME OF CEMETERY OR CREMATORY: Indian Mound Cemetery

23d. LOCATION (City or Town) (County) (State): Romney, Hamp. W.Va.

24. FUNERAL DIRECTOR: Thrush Funeral Home - By Earl D. Thrush — ADDRESS:

25a. REC'D BY REGISTRAR DATE: AUG 22 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10818

CERTIFICATE OF DEATH

12154

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 20 LONG DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MRS. Middle MYRTLE Lost J. UMSTOT

4. DATE OF DEATH Month AUG. Day 31 Year 19 66

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 9/2/07
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) W.VA. Fort Ashby
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE DERMER
14. MOTHER'S MAIDEN NAME ELIZABETH MC KEAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Amyotrophic Lateral Sclerosis
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Date July '65

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8. 2. , 1965 to 8. 31. , 1966 that (I) (we) last saw the deceased alive on 8. 30. 19 66 and that death occurred at 10.05 AM from causes and on the date stated above.

22a. SIGNATURE Wm. F. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8. 31. 66
22c. PHYSICIAN'S NAME (Type) DR. W.F.WILLIAMS
22d. ADDRESS 122 S.CENTRE ST. CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Sept.2,1966
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State) Cumberland,Md. Allegany

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland,Md.
25a. REC'D BY REGISTRAR DATE SEP 8 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Stanley Thomas Leiter

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10813

CERTIFICATE OF DEATH

10811

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4½ days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Pa.
d. STREET ADDRESS: Union St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Herbert		Wagner	8/	3	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	10/3/[illegible]-1887	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpentar	Building	Salisbury Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Wagner	Rebecca Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	172-18-2232	Mrs Edna E. Robinson, Salisbury, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Opplectic Stroke — INTERVAL BETWEEN ONSET AND DEATH: 2 month
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis — 1 year
DUE TO
(c):

334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-1, 1966, to 8-3, 1966, that (I) (we) last saw the deceased alive on 8-2 1966, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: L. Briggs — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-3-66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	AUG 5-1966	SALISBURY-I.O.O.F.	SALISBURY-SOMERSET-CO-PA

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Stanley M Thomas Salisbury, Pa	AUG 9 1966	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10820

CERTIFICATE OF DEATH

10812

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: 1 WEEK
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCIS; Middle; Last WALSH

4. DATE OF DEATH: Month AUGUST; Day 16; Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT. 25, 1886

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF-EMPLOYED

10b. KIND OF BUSINESS OR INDUSTRY: PAPER HANGER

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES WALSH

14. MOTHER'S MAIDEN NAME: ELLEN ARNOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. MARY BUTLER, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b): Hypertensive cardiovascular disease — 5 years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 11, 1966, to Aug 16, 1966, that (I) (we) last saw the deceased alive on Aug. 16 1966, and that death occurred at 6 P. M, from causes and on the date stated above.

22a. SIGNATURE: G Paige Strong — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 18, 1966

22c. PHYSICIAN'S NAME (Type): A. PAIGE STRONG, M.D.

22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 19, 1966

23c. NAME OF CEMETERY OR CREMATORY: JOHNSON'S CEMETERY

23d. LOCATION (City or Town) (County) (State): GARRETT COUNTY, MD.

24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: AUG 22 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10821

CERTIFICATE OF DEATH

10813

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 56 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1308 LEXINGTON AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARTHUR — Middle: EUGENE (S.) Stanton — Last: WHISNER

4. DATE OF DEATH: Month: AUGUST — Day: 9 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-26-1909

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: JOHN WHISNER

14. MOTHER'S MAIDEN NAME: CORA GORDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO (b): Coronary Arteriosclerosis — 17 Yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-6-66 2:23 A.M. to 4-9-66, 19__, that (I) (we) last saw the deceased alive on 8-1-66 19__, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/9/66

22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.11,1966

23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Garden

23d. LOCATION (City or Town) (County) (State): CumberlandMd.Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10822

CERTIFICATE OF DEATH

10814

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/17/1965
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 808 Ashland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida; Middle: May; Last: White

4. DATE OF DEATH: Month: August; Day: 11; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/28/1878

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Martinsburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Burkhart

14. MOTHER'S MAIDEN NAME: Anna Gearhardt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: P.O.Box 599, Address: Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Arteriosclerotic Senile
DUE TO (b): (2) Arterio Sclerosis & Hypo tension
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): (3) Bilateral Cataracts (Operated)
4221
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/17/65, 19___, to 8/11/66, 19___, that (I) (we) last saw the deceased alive on 8/10/66 19___, and that death occurred at 5:30 A. M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 8/11/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 12, 1966

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: AUG 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G379 8/17/66 mn

10823

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10815

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 47 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 31½ Pennsylvania Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Junior — Last Wolf

4. DATE OF DEATH: Month Aug. — Day 7 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 6, 1920

9. AGE (In years last birthday): 46 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Band Sewer

10b. KIND OF BUSINESS OR INDUSTRY: Tire Industry

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thurman E. Wolf

14. MOTHER'S MAIDEN NAME: Leoda Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217-10-7463

17. INFORMANT — Address: Mrs. Charlotte Wolf, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO (b): Coronary Sclerosis — ----
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Aug. 8, 1966

Address (Street, city, town, or county): Rt. 9 Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 10, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (6) 6M 1/66